

Step 1 – Work Description

Requestor: _____ Date: _____ Phone: _____ Organization: Division: _____ Group: _____ UserID: _____
 Proposed Start Date: _____ Required Completion Date: _____ Location of Work: _____
Task: Repair/Testing Maintenance/1-for-1 New/Modified Installation Labyrinth/Mini-Hutch **Risk Level:** Low Medium High
Component Type: Shutter/ACIS Stop Radiation Shielding PSS/ACIS **RSS Other:** _____ RSS Label: _____
Machine: LINAC PAR Booster Zone F Storage Ring LEUTL Front Ends Experimental Floor
WORK REQUEST #: _____

Step 2 – JOB TITLE: _____

Job Description: (work plan, approved drawings, procedure/checklist references, etc.) _____

PROCEDURE/CHECKLIST #: _____

DIVISION APPROVAL TO PROCEED ICMS #: _____

Work Approvals:

Alternate approval workflow per Policy on Design, Installation and Maintenance of Radiation Safety Systems (APS_1189715)

	Approval Signature	Date	Approval Signature	Date
Safety Interlocks:	_____	_____	Mechanical/Water:	_____
Vacuum:	_____	_____	Survey/Alignment:	_____
RF/PS/Diag/CTL:	_____	_____	MED:	_____
Health Physics:	_____	_____	ADD:	_____
MCR/OA:	_____	_____	CCSM:	_____

Step 3 – Authorization to Start. Information (drawings, specs, procedures, approval/validation checklist requirements, review committee recommendations etc.) are adequate to safely complete work, requested work is consistent with an approved design, and a pre-work briefing has been held.

(RSSE, Responsible Engineer) : _____ Date : _____
 Stations Enabled: _____ Stations Disabled: _____ Global: On-line Off-line
 MCR/Floor Coordinator: _____ Date : _____

Step 4 – Validations: Responsible Engineer indicates work has been completed, validated, all safety concerns have been resolved, and all appropriate records have been updated.

	Approval Signature	Date	Approval Signature	Date
Safety Interlocks:	_____	_____	Mechanical/Water:	_____
Vacuum:	_____	_____	Survey/Alignment:	_____
RF/PS/Diag/CTL:	_____	_____	MED:	_____
Health Physics:	_____	_____	ADD:	_____
MCR/OA:	_____	_____	Other	_____

Step 5 – Close out complete: All work and validations completed.

CCSM : _____ Date: _____
 Floor Coordinator / MCR : _____ Date: _____
 RSSE / Responsible Engineer : _____ Date: _____

Step 6 – Return to service. Type C Radiation Survey Required: Yes No Survey Completed (HP) : _____ Date: _____
 Device/system ready to return to service, on-line status restored: Floor Coordinator / MCR: _____ Date: _____

Comments: